

1. Introduction

I welcome the opportunity to provide a submission regarding the Productivity Commission Interim Report into Mental Health & Suicide Prevention Agreement Review, which is provided by way of my comments & suggestions/ideas for increasing effectiveness of Report content and recommendations.

Whilst I acknowledge that the timing in providing my comments and suggestions/ideas may not be well aligned with the current status of the Interim Report and proposed next steps for implementation, I am hoping that they will at least be read and may help in improving effectiveness in strategies to address the significant problems that have plagued the mental health system and suicide prevention strategies in Australia for so many years.

My hope for ideas offered is that there may be something suggested that provides a 'spark' or starting point for an improvement opportunity. It's really my 'outpouring' of ideas formulated over the last 26 years of our Mental Health journey with our daughter, and more recently our son who was recently diagnosed with ADHD. Hence please do not disregard everything if some of my ideas are implausible.

I also reinforce that I would welcome any questions or feedback on any statements included in this submission and would be very happy to provide additional information or details if so required.

2. Background

My comments and suggestions are based on many years of involvement with mental health system shortcomings and deficiencies, which my family and I have personally experienced. In short, the mental health system is **broken**, being severely lacking in its ability to provide fundamental services such as those for early detection, effective diagnosis, and services provision.

In particular the 'system' fails significantly in relation to the fundamental ability to access effective services in an affordable and timely manner, as well as for provision of effective critical intervention in times of life-threatening situations. There has been little or no change since our 'journey' began over 26 years ago! There are still people, many of them our precious children, taking their own lives in desperation due to a broken mental health system! This is not good enough and **MUST CHANGE!**

Our experience relates to our daughter who has suffered a range of mental health issues for over 26 years, including life-threatening anorexia and bulimia, self-harm, substance addiction, extreme repetitive risk-taking behaviours. The trigger for this was severe bullying that our daughter suffered at school when she was 13 years old because of her behaviours arising from her underlying OCD. This put our daughter and us on a mental health 'journey'

with all our lives spirally in a direction that we could not have imagined in our worse nightmares! The system completely failed us with regards to effective diagnosis and treatment for her extremely complex issues, resulting in multiple suicide attempts and other extremely high-risk behaviours. Various 'so-called' mental health system professionals gave up on our daughter and us, advising that she could not be helped and would likely not survive more than a few weeks!!

The critical system failure was in the form of a local adolescent psychiatric facility, in which our daughter spent over 50% of her formative years between 13 and 16. The so-called experts were totally inadequate to help our daughter, hypothesising various diagnosis (which were all wrong), prescribing a range of anti-psychotic, anti-depressive and anti-anxiety medications, providing totally ineffective therapies and exposing our daughter to additional risks from some older 'street-wise' predatory boys who shared the mixed ward! They were supposed to help but totally mismanaged our daughter's care, comprising extreme negligence! They were supposed to help but ended up making things much, much worse, with our daughter's life totally spirally out of control to the point that she ultimately our daughter lost hope completely and walked in front of a car when she was 17, resulting in a traumatic brain injury.

Our experiences with our daughter also highlighted the total system failings in relation to services available in life-threatening mental health episodes. This included lack of assistance from telephone helplines, emergency response mechanisms, usually ambulance officers assisted by Police who transported our daughter to a local public hospital ED, sometimes in handcuffs, which still haunts us to this day! Whilst the ED personnel were effective in treating medical issues, they were totally inadequate in addressing the underlying mental health issues.

Our son has also suffered from the inadequacies of the mental health system in relation to ineffective services relating to ADHD, likely exasperated by trauma our son experienced during his formative early years in witnessing his sister's life spiralling out of control due to mental health system failings. Our son was finally diagnosed with ADHD last year, but experienced 'system' failings in relation to severe deficiencies in access to affordable and timely services for diagnosis, availability of effective treatments and coordination of treatment management between ADHD professional services and his GP.

We have learnt a lot through our experiences gained over our 'mental health journey' with have shared with our daughter over the last 26 years and more recently our son. The vast majority of what we have learnt is 'what doesn't work' and a few instances of 'what does work'. An example of what does work is an eating disorder program that saved our daughter's life. This was a little-known 'out-patient' program that was extremely simple yet

powerful in its approach, as opposed to the more highly recognised hospital-based programs being offered at the time which were complicated, extremely controlling and all totally ineffective! One particular program offered by a local public hospital, which was highly regarded by peers both then and now, was based on archaic out-dated techniques which many overseas hospitals had disregarded many years before!

Hence our strong preference is for simple yet effective treatments and therapies, minimising the use of strong medications whenever possible.

It seems to us that some mental health therapies have been developed by individuals and their peers, without due regard to other therapies and approaches used elsewhere both nationally and internationally, some of which may be more effective.

3. Comments

I offer the following comments in relation to the Interim Report, which are complimented by my 'Ideas for Improvement':

- i. Given the fact that there have been 6 Agreements to date and the Report acknowledges that “Mental health and suicide prevention outcomes have not improved over the term of the Agreement”, as reinforced by the ‘Draft findings’, it is obvious that the Agreement and underlying foundations have inherent shortcomings or flaws. These fundamental issues are preventing the the achievement of improvements and changes that are so desperately required.
- ii. I note that ‘Draft recommendation 4.2 recommends an “extension of the Agreement until June 2027 to enable sufficient time to develop the foundations of the next Agreement and National Mental Health Strategy”. Whilst I acknowledge and support this (“why implement it if it’s flawed?”), it is imperative that some key actions are identified and implemented as a matter of priority to address immediate critical needs arising from historical mental health system shortcomings.

Hence, I believe there needs to be an approach comprising immediate/short-term, medium term and long-term objectives directly linked to ‘SMART’ Targets, being Specific, Measurable, Achievable, Realistic and Time-based actions to be applied.

- iii. It is not apparent if the overall strategy includes underlying defined metrics comprising performance measures to gauge effectiveness of actions taken, facilitating the ‘Measurable’ part of the SMART Targets. If that is not the case this should be done as a priority, with each Agreement clearly stating objectives and effectiveness of the

Agreement over the validity period against relevant SMART Targets and applicable metrics.

- iv. It is imperative that a 'consumer representatives' be involved on an ongoing basis for all aspects of a Mental Health & Suicide Prevention strategy to ensure that it is truly consumer focussed and driven, including agreement of the underlying needs and 'drivers', development of strategy foundations, objectives, performance metrics and SMART Targets to gauge effectiveness, and for ongoing review and continual improvement.
- v. The system currently in place for ADHD is convoluted with inherent problems, being:
 - Long waiting times and extremely prohibitive costs applicable for assessment by a health care professionals, typically being psychiatrists.
 - Lack of professionals who can diagnose ADHD.
 - Assessments by a particular 'ADHD professional' are not readily accepted, if at all, by other 'ADHD professionals' for management of ADHD medications and/or other treatment options, with some requiring a re-assessment by them.
 - Disconnect between the 'ADHD professionals' conducting the assessment and GPs given the responsibility for managing medications and other treatment options.
 - Lack of availability and excessive costs for alternative treatment options, including ADHD Coaches.
 - No mechanisms for early identification, assessment, and intervention for ADD or ADHD. Ideally needs to be done at preschool and schools, in conjunction with appropriately qualified personnel.
 - Problems with availability of ADHD medication, which typically needs to be changed or adjusted to suit individual needs.

4. Ideas for improvement and REAL change

These ideas arise from our experiences with mental health system deficiencies and shortcomings over the last 26 years, during which we have supported our daughter and son, as detailed above. Whilst they are our personal ideas, we are hoping that there may be something that could be adopted in some way to assist in improving the approach to mental health and suicide prevention in Australia.

- Review the current 'model'. Is it truly consumer-focussed and outcome driven as opposed to being driven for political point-scoring to appease voters? Why waste millions of taxpayers' dollars on something that just won't work?

All stages of the process should include effective involvement of consumer representatives in committees, during reviews, development, implementation, and ongoing reviews. Consumer representatives would constitute people who have personal and 'lived' experience with mental health and/or suicide, as experienced by

them or those close to them, with the appropriate personal attributes and 'skills set' to effectively execute the role.

- Review the current approach and underlying foundations as the basis for an effective mental health and suicide prevention strategy. Is it sound and the best approach to maximise outcomes and instigate real positive changes?
- The review should include identification of 'best-practice' models on an international basis? Why 're-invent the wheel' if someone is doing it well already?
- Develop the overall strategy, objectives, performance measures/metrics and SMART Targets, as the basis for government approval and funding. The approach needs to include immediate/short-term, medium term and long-term objectives directly linked to 'SMART' Targets.
- The metrics would be critical because they provide the basis for performance measurement/overall effectiveness of the strategy. They should not be purely based on historical statistics such as mental health attributed deaths or suicide but also consider suicide attempts, critical care helpline contacts and hospital presentations. They could also potentially consider and include mental health related crime statistics, and even early detection at schools.
- The strategy should include education and mechanisms for training and support services enabling early identification, assessment, and effective treatment, targeting parents, preschools/ schools, workplaces, correctional services, and the broader community. Early identification and intervention for mental health issues is what's always been poorly lacking and is so badly required to prevent potential escalation to life-long, life-altering, or life-threatening conditions.
- Transparency should be key at all stages to encourage community confidence and support that 'things are working' as planned and actions taken have been effective.

A **HIGH PRIORITY** should be assigned to the immediate/short-term SMART targets to address historical and current deficiencies in critical services/crisis support access and provision. These are things that don't currently work at all and must be addressed ASAP, including:

1. Critical Intervention/Crisis Support Services for life-threatening episodes.

Those were ineffective for my daughter many years ago, and a recent discussion with someone whose partner has BPD and ADHD highlighted that those services still don't work! She related that recently her partner, being in a highly suicidal state, rang a helpline and was recommended to attend a hospital ED, which he did. After waiting hours he was assessed and referred to community mental health services

but given no details as to where they were or how to access them. So it was left to her to support her partner which thankfully helped him through this extremely challenging time.

What I feel is required are Critical Intervention/ Crisis Support Services comprising:

- a. A **phone-based support service** which is immediately available and easily accessible 24/7 with personnel sufficient capacity, training, and resources to perform an initial higher-level triage to assess risk and recommend immediately available treatment services. Initial triage would ideally incorporate a simplified 'Root-cause Analysis' to differentiate between drug-induced incidents and others to collect relevant information and facilitate appropriate subsequent services.

Ideally this service:

- Accommodate calls from family members or friends of the person in crisis, with appropriate 'checks & balances' if that person is at risk to themselves or others but is reluctant to call themselves.
- Could facilitate timely attendance by Crisis Support personnel and/or transport to 'In-person treatment services' in instances deemed critical.
- Would ensure that information obtained would ideally be readily available by subsequent services personnel.
- Would comprise a 'one-stop-shop' model to effectively support and help those in crisis.
- Would provide a follow-up service to ensure the people contacting them have received appropriate assessment and treatment.
- Could potentially link into an advocacy support service to the people in crisis.

- b. **'In-person treatment'** services:

- Must be readily available 24/7 and accessible for immediate assessment and treatment. Ideally these would be community-based services, such as 24/7 Medicare Mental Health Centres. *I noted these are mentioned in the Interim Report but personally have no knowledge about their existence or location!*
- If hospital based, should be separate from the ED for medical/non-mental health issues, to ensure timely and effective services provision, as well as reducing pressure on and eliminating potential risks to already thinly stretched medical ED personnel.
- Must be sufficiently resourced and operated by appropriately trained mental health personnel.
- Would conduct a detailed triage including a risk-assessment, performed by personnel appropriately experienced and trained in mental health and

suicide prevention, and considering information obtained from the phone-based service .

- Would, based on outcomes of the detailed triage and risk assessment, either discharge the client or arrange a presentation (and if possible, transport) to appropriate 'in-patient' or 'out-patient' Treatment Services.
- In either case, arrange timely follow-up contact with the 'person-in-crisis' to ensure that appropriate Treatment Services have been accessed to minimise the risks.

Any Treatment services referred must be available for provision of timely and affordable services, irrespective of the mental health issue, including ADHD. This also applies to any short, medium or long term treatment services required by mental health professionals. The services must be available within a reasonable timeframe, proportionate to the severity of the mental health issue and be affordable, which is not currently the case!

Key points include:-

- All services must be immediately available and easily accessible 24/7 and sufficiently resourced by appropriately experienced and trained personnel.
- Sharing of information between services from the initial phone-call would enable ready sharing of essential information and negate the need for the 'person-in-crisis' to repeat basic information repeatedly.
- Allocation of an Advocate or Support Person would provide support for the 'person-in-crisis' and family members/friends throughout the process and ensure that required follow-up treatment is actually provided and is effective.
- 'In-person treatment' services for mental health issues to be available separately from medical admissions, especially in EDs.
- Follow-up services to be arranged by personnel conducting the triages and assessments, including arranging appointments and providing transport if required.

5. ADHD- requires improvements to:

6. Provide mechanisms for early identification, assessment, and intervention for ADD or ADHD. Ideally needs to be done at preschool and schools, in conjunction with appropriately qualified personnel.
- Ensure that services required for assessment and ongoing management of ADHD are readily available and affordable- ideally covered by Medicare?/
 - Optimise GPS managing medication/other therapies post-assessment and eliminating communication barriers between the GP and the specialist who conducted the assessment.
 - Ensure that other treatments/therapies are readily accessible and affordable, such as ADHD Coaches.